Heart Of Texas Cardiology, P.A.

2911 Medical Arts Street, Bldg.. 10
Austin, Texas 78705
David Hayes, M.D. 512-474-5551 David Garza, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Please Print)

Patient Name: _____

Date of Birth: _____ SSN: _____

Home Address: _____

Mailing Address: _____

Home Phone #: _____ Work Phone#: _____X_____

All of the following information must be provided in order for us to process your request.

Records Released **From**: (previous physician)

_____
Physician or Clinic Name

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Records **Sent To:**

Heart of Texas Cardiology, P.A.
2911 Medical Arts Street, Bldg. 10
Austin, Texas 78705
Phone: 512-474-5551
Fax: 512-474-7324

Please release the following for date(s) of treatment from: _____ to: _____

- ☐ History & Physical
- ☐ Laboratory Reports
- ☐ EKG (s)
- ☐ Treadmill Reports
- ☐ Nuclear Reports
- ☐ Hospital/Operative Report(s)
- ☐ Echo
- ☐ Holter Reports
- ☐ Other (please specify) _____

PURPOSE OR NEED FOR DISCLOSURE:

- ☐ Primary Care Physician
- ☐ Consultation
- ☐ Disability Determination
- ☐ Transfer of Care
- ☐ Insurance
- ☐ Payment of Claim
- ☐ Other (please specify) _____

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to party noted above. I understand that I may revoke this authorization at any time except to the extent that the action has been taken in reliance on it. This authorization will expire in one year from the date of my signature or as otherwise specified by date, or events of conditions as follow: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date